

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13102

Reg. Dist. No.

11

13132

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 8 Sunset Drive		
3. NAME OF DECEASED (Type or print) First EARL Middle ABRECHT Last ABRECHT			4. DATE OF DEATH Month December Day 26 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 18, 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic U.S. Govt.-Automobiles		10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George F. Abrecht			14. MOTHER'S MAIDEN NAME Mary Elizabeth Esterly		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-9187		17. INFORMANT Same as item #2 Mrs. Virginia Ethel Bowings Abrecht	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Maryland	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. B. O. Thomas, Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Dec. 26, 1957	
EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 28, 1957	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 27 Dec. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 30 1957

Reg. Dist. No.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Detroit, Mich.		Detroit, Mich.		Heart Disease		Jan 15, 1945		10:00 AM		St. Mary's Hospital		J. A. Smith		W. B. Jones	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice	
Teacher		Married		None		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940		Jan 1, 1940	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
John Doe		Jane Doe		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones	

DEC 27 195

RECEIVED

BUREAU V. S.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

Items 20&21 Film 224 1-15-58 ams

13134

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Bural c. LENGTH OF STAY IN 1b 3 mo d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Bural d. STREET ADDRESS 15X12 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Larry Barnhouse		4. DATE OF DEATH Month Day Year December 30 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24-1943
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carroll Barnhouse		14. MOTHER'S MAIDEN NAME Rachel Best	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr Carroll Barnhouse, Dickerson, Rt. 1--Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning Accidental 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Months	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) # Waded in the river after a boat # Went in deep water & drowned.	
20c. TIME OF INJURY Month, Day, Year Hour 4:30 p.m. 12-30- 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) #		20f. (City or town) (County) (State) Mr. Dickerson Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. Thorne EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2-1958	
22c. NAME OF CEMETERY OR CREMATORY None Cacy		22d. LOCATION (City, town, or county) (State) Boothville Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Bethesda, Md		24a. REC'D BY REGISTRAR DATE 1/6/58	
		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____
2. Sex: _____
3. Age: _____
4. Date of Birth: _____
5. Place of Birth: _____
6. Date of Death: _____
7. Place of Death: _____
8. Cause of Death: _____
9. Manner of Death: _____
10. Signature of Medical Examiner: _____
11. Date of Signature: _____

RECEIVED
JAN 7 1933
BUREAU V. S.

100-1-1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13:06

CERTIFICATE OF DEATH

131081

Reg. Dist. No. 712

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Dickinson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wanda</u> Middle <u>Jean</u> Last <u>Barnhouse</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 Feb 57</u>	
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR Months <u>8</u>		IF UNDER 24 HRS. Days <u>8</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Carroll Barnhouse</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Best</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mother</u>		Address <u>Dickinson Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mucoviscidosis</u> <u>756.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5-MO</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>24 Dec</u> , 19 <u>57</u> to <u>25 Dec</u> , 19 <u>57</u> that I last saw the deceased alive on <u>25 Dec</u> , 19 <u>57</u> , and that death occurred at <u>2:30 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 N. Lakeside St.</u> DATE SIGNED <u>26 Dec 57</u>							
ACTUAL SIGNATURE <u>A. M. Powell, Jr.</u> M.D. <u>Frederick Md.</u>							
PHYSICIAN'S NAME (Type) <u>A. M. Powell, Jr.</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>				ADDRESS <u>Barnevillle Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/28/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elyshek</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13135

CERTIFICATE OF DEATH

13107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. LENGTH OF STAY IN 1b 35 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Haidee Middle V. Last Beard				4. DATE OF DEATH Month December Day 4 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1884		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher retired		10b. KIND OF BUSINESS OR INDUSTRY Public school		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME M.L. Beard				14. MOTHER'S MAIDEN NAME Catherine Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Lester Birely		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec. 2, 1957 , to Dec. 4, 1957 , that I last saw the deceased alive on Dec. 4, 1957 , and that death occurred at 11 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Franklin Birely M.D.				ADDRESS (Street, city or town, state) Thurmont, Md.		DATE SIGNED 12/5/57	
PHYSICIAN'S NAME (Type) M. Franklin Birely				Thurmont, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-57		22c. NAME OF CEMETERY OR CREMATORY Middletown Luthern Cem		22d. LOCATION (City, town, or county) (State) Middletown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Maryland		24a. REC'D BY REGISTRAR Dec 57	
				24b. REGISTRAR'S SIGNATURE Carl...			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

DEC 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13107

CERTIFICATE OF DEATH

13108

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 321 Catoctin Ave.	
d. STREET ADDRESS 321 Catoctin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle William Last Bennett		4. DATE OF DEATH Month Dec. Day 28 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-1885
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bennett		14. MOTHER'S MAIDEN NAME Mary Burdette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-18-1723	
17. INFORMANT Mrs. John W. Bennett-321 Catoctin Ave.-Frederick		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with 420.0 DUE TO auto myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hour			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 to Dec 28, 1957 , that I last saw the deceased alive on Dec 28, 1957 , and that death occurred at 10:30A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 East Church St. Frederick-Maryland DATE SIGNED 12-30-57			
ACTUAL SIGNATURE Rex R. Martin M.D.		DATE SIGNED 12-30-57	
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		ADDRESS Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-1957	
22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Airy-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. E. Cline & Son		24a. REC'D BY REGISTRAR DEC 31 1957	
ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE Ely G. Glick	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1957	
AGE		SEX	
70 yrs		M	
PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE, MD		JAN 10 1887	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		JAN 10 1910	
OCCUPATION		DATE OF OCCUPATION	
RETIRED		JAN 10 1950	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH	
HEART DISEASE		JAN 10 1957	
PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MD		JAN 10 1957	
SIGNATURE OF DECEASED		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 10 1957	
SIGNATURE OF WITNESS		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 10 1957	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 10 1957	
SIGNATURE OF CORONER		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 10 1957	
SIGNATURE OF BURIAL		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 10 1957	

BUREAU V. S.

DEC 31 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Graceham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last Otto Leonard Boller				4. DATE OF DEATH Month Day Year December 16 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1897	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ford Company				10b. KIND OF BUSINESS OR INDUSTRY Assembly worker		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles M. Boller				14. MOTHER'S MAIDEN NAME Effie M. Firor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WORLD-WAR 370-07-5932		17. INFORMANT Raymond Boller	
				Address Graceham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of esophagus & Stomach 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —				INTERVAL BETWEEN ONSET AND DEATH 13 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 11, 19 57, to Dec. 16, 19 57, that I last saw the deceased alive on Dec. 11, 19 57, and that death occurred at 9 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. Gray				M.D. Thurmont-Md. 12/16/57			
PHYSICIAN'S NAME (Type) Dr. James K. Gray				Thurmont-Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE DEC 19 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13108

CERTIFICATE OF DEATH

13110

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b lifelong			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VINDOBONA CONVRLESENT HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARA M. WILCOXIN BROWN.				4. DATE OF DEATH DEC. 15, 1957.			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1863.	9. AGE (In years last birthday) 94. yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY homemaker.	11. BIRTHPLACE (State or foreign country) Frederick, Md.	12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Andrew Jackson Wilcoxin.				14. MOTHER'S MAIDEN NAME Anna Mary Getzendanner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-10-5138			
				17. INFORMANT Miss. Anna W. Brown, Daughter.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sensitivity DUE TO (c) Carcinoma of Bladder							INTERVAL BETWEEN ONSET AND DEATH 2 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Broncho Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 56 , to Dec 15 , 19 57 , that I last saw the deceased alive on Dec 14 , 19 57 , and that death occurred at 12:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE H. L. FAHRNEY, MD.							
PHYSICIAN'S NAME (Type) H. L. FAHRNEY, MD.				FREDERICK MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 17, 1957.	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) FREDERICK, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME ADDRESS FREDERICK, MARYLAND.				24a. REC'D BY REGISTRAR 18 Dec 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Hark		

CERTIFICATE OF DEATH

BUREAU V. 1

DEC 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13111

13109

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crutchley Nursing Home-708 N. Mkt. St.				d. STREET ADDRESS 627 Park Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle E. Last Brunner				4. DATE OF DEATH Month Dec. Day 17 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. XXXXXX WIDOWED		8. DATE OF BIRTH Nov. 26-1884	
9. AGE (In years last birthday) 73 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE (In years last birthday) 73 yrs.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James E. Weddle				14. MOTHER'S MAIDEN NAME Rebecca Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Frederick-Md. Miss Margaret A. Brunner-627 Park Place-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 wks 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1952 , to Dec 18, 1957 , that I last saw the deceased alive on Dec 18, 1957 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 West Third St. DATE SIGNED							
ACTUAL SIGNATURE Thomas E. Stone M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone				ADDRESS Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Elline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR DATE 21 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hersh	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 3

DEC 26 1957

RECEIVED

13137

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle A. Last Bussard				4. DATE OF DEATH Month 12 Day 8 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/1893	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mech. engineer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles A Bussard				14. MOTHER'S MAIDEN NAME Minnie Gaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or date of service)				16. SOCIAL SECURITY NO. 212-10-8229			
17. INFORMANT Mrs. Nannie Bussard				Address Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 5-6 years (c)						INTERVAL BETWEEN ONSET AND DEATH, 5-10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 5, 1957 to Dec 8, 1957 , that I last saw the deceased alive on Dec 5, 1957 , and that death occurred at 8:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth C. Henson				ADDRESS (Street, city or town, state) Middletown, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. Kenneth Henson				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/1957		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.				24a. REC'D BY REGISTRAR DATE 13 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. CASE NO.

Form fields for death certificate including: NAME OF DECEASED, SEX, AGE, DATE OF BIRTH, PLACE OF BIRTH, OCCUPATION, CAUSE OF DEATH, and SIGNATURE OF PHYSICIAN.

*Death occurring within
the first three*

BUREAU V. S.

DEC 16 1957

RECEIVED

*Dec 2 1957
Dec 2 1957
Dec 2 1957
Dec 2 1957*

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13110 CERTIFICATE OF DEATH

13114
(13114)
Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN b. 45 Years		d. STREET ADDRESS 120 East Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle HENRY Last CARTNAIL		4. DATE OF DEATH Month December Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 May 1896
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dray Truck	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Cartnail		14. MOTHER'S MAIDEN NAME Hester Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-0699	
17. INFORMANT Mrs. Emma Cartnail (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to Dec 14 , 19 57 , that I last saw the deceased alive on Dec 14 , 19 57 , and that death occurred at 10:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 35 E. Church St., Frederick, Md. 12-16-57			
ACTUAL SIGNATURE Rex R. Martin		M.D. 35 E. Church St., Frederick, Md. 12-16-57	
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-57	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR DATE 18 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

BUREAU V. S.

13138

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH o. COUNTY FREDERICK-BRUNSWICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BRUNSWICK MD.				d. STREET ADDRESS 35 BRUNSWICK			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY CRAVER				4. DATE OF DEATH Month Day Year 12 3 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-27-1889	
9. AGE (In years lost, birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES E. CRAVER		14. MOTHER'S MAIDEN NAME EMMA E. POWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HARRY W. WOLF		Address BRUNSWICK MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 450.0 DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 4 4			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/2 , 19 57 , to 12/3 , 19 57 , that I last saw the deceased alive on 12/2 , 19 57 , and that death occurred at 2:4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) [Address]			
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED 12/3/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-6-57		22c. NAME OF CEMETERY OR CREMATORY UTICA CEMETERY		22d. LOCATION (City, town, or county) (State) UTICA MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Elva D. Feete				ADDRESS Brunswick Md.		24a. REC'D BY REGISTRAR 82-8-07	
24b. REGISTRAR'S SIGNATURE Eugenia D. Bucke							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		M		35		W		12/1/22		MOBILE, ALABAMA	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
12/6/68		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		[Signature]		[Signature]	
13. FULL AND COMPLETE LIST OF ALL DISEASES AND CONDITIONS PREEXISTING AT THE TIME OF DEATH, AND ALL TREATMENT RECEIVED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF ADMISSION.											
14. FULL AND COMPLETE LIST OF ALL MEDICATIONS AND TREATMENTS RECEIVED BY THE DECEASED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF ADMINISTRATION.											
15. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED ON THE DECEASED, INCLUDING THE NAME OF THE SURGEON, HOSPITAL, AND DATE OF OPERATION.											
16. FULL AND COMPLETE LIST OF ALL OTHER MEDICAL PROCEDURES PERFORMED ON THE DECEASED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF PROCEDURE.											
17. FULL AND COMPLETE LIST OF ALL OTHER MEDICAL PROCEDURES PERFORMED ON THE DECEASED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF PROCEDURE.											
18. FULL AND COMPLETE LIST OF ALL OTHER MEDICAL PROCEDURES PERFORMED ON THE DECEASED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF PROCEDURE.											
19. FULL AND COMPLETE LIST OF ALL OTHER MEDICAL PROCEDURES PERFORMED ON THE DECEASED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF PROCEDURE.											
20. FULL AND COMPLETE LIST OF ALL OTHER MEDICAL PROCEDURES PERFORMED ON THE DECEASED, INCLUDING THE NAME OF THE PHYSICIAN, HOSPITAL, AND DATE OF PROCEDURE.											

BUREAU V. S.

DEC 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

13139 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

13116

Reg. Dist. No. 141

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>Maryland</u> o. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1119 N. 6th Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DINTERMAN, JOHN C.</u>		4. DATE OF DEATH <u>DEC. 25 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890 67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PEARL MARILAND U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JACOB M. DINTERMAN</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL LARE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RAYMOND DINTERMAN</u>		Address <u>HAGERSTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 18 1957</u> to <u>Dec 25 1957</u> , that I last saw the deceased alive on <u>Dec 23 1957</u> and that death occurred at <u>3:00 P</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Rosemont, C/O. Knoxville, Md</u>	
ACTUAL SIGNATURE <u>Jules F. Langlet</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JULES F. LANGLET</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>12-28-57</u>	<u>Park Heights</u>	<u>Brunswick Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elva V. Teete</u>		24a. REC'D BY REGISTRAR <u>12-29-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Eugenia H. Burke</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form No. 10-58

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARITAL STATUS		OCCUPATION	
JAMES EARL RAY		MAY 19 1928		MALE		WHITE		SINGLE		CLOCK REPAIRER	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		APR 4 1968		10:00 PM		MEMPHIS, TENN.		HEART DISEASE		SUICIDE	
EDUCATION		RELIGION		SIGNED BY		DATE		PLACE		TITLE	
HIGH SCHOOL		METHODIST		JAMES EARL RAY		APR 4 1968		MEMPHIS, TENN.		DECEASED	
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS SUICIDES		PREVIOUS MENTAL ILLNESS		PREVIOUS DRUG ABUSE		PREVIOUS ALCOHOL ABUSE	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS MENTAL ILLNESS		PREVIOUS DRUG ABUSE		PREVIOUS ALCOHOL ABUSE		PREVIOUS SUICIDES		PREVIOUS DEATHS		PREVIOUS RELIGION	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DEATHS		PREVIOUS SUICIDES		PREVIOUS MENTAL ILLNESS		PREVIOUS DRUG ABUSE		PREVIOUS ALCOHOL ABUSE		PREVIOUS MARRIAGES	
NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS ALCOHOL ABUSE		PREVIOUS DRUG ABUSE		PREVIOUS MENTAL ILLNESS		PREVIOUS SUICIDES		PREVIOUS DEATHS		PREVIOUS RELIGION	
NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. S.

DEC 31 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13111 CERTIFICATE OF DEATH

Reg. Dist. No. 191

13117

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURKITTSTVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURKITTSTVILLE, Md. 21X22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catherine Louise Dorsey				4. DATE OF DEATH 12 6 1957			
5. SEX F		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5 1916	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) BURKITTSTVILLE				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LOUIS SPRIGGS				14. MOTHER'S MAIDEN NAME HATTIE BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO				16. SOCIAL SECURITY NO. —			
17. INFORMANT KATHERINE F. SPRIGGS				Address BURKITTSTVILLE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive Heart failure DUE TO Rheumatic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs + DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490 Talar pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/24 , 19 57 , to 12/6/57 , 19 57 , that I last saw the deceased alive on 12/5 , 19 57 , and that death occurred at 12:20 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 12/6/57 ACTUAL SIGNATURE Henry V. Chase M.D. Frederick Md PHYSICIAN'S NAME (Type) Henry V. Chase							
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 9		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery St. Mary		22d. LOCATION (City, town, or county) (State) Petersville - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elva V. Tette Brunswick Md.				24a. REC'D BY REGISTRAR DATE 12-9-57		24b. REGISTRAR'S SIGNATURE Eugenia H. Burke	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Charles V. Johnson</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Dec 11 1957</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>None</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	
DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>	

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DEC 11 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13118 131

13112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>50 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lura</u> Middle <u>Irene</u> Last <u>Dougherty</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/88</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick CO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jacob Flickinger</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hildebrand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Baxter C. Dougherty Detour, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>944.0</u> (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>5 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Fracture of left femur 2) Obesity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell at home</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>11</u> 1957		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) <u>Detour</u>		20f. (County) <u> </u>		20g. (State) <u>Md</u>			
21. I certify that I attended the deceased from <u>11/7</u> , 19 <u>57</u> , to <u>12/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/21</u> , 19 <u>57</u> , and that death occurred at <u>5:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E Church St</u> DATE SIGNED <u>12/22/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Haugh's nr. Ladiesburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>				ADDRESS <u>Thurmont, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF FUNERAL HOME</p>	

RECEIVED
DEC 24 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 9 Film 223 12-18-57 etc

CERTIFICATE OF DEATH

Reg. Dist. No. 131144

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>35 BRUNSWICK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>213 DELAWARE AVENUE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Lee</u> Last <u>Eddins</u>				4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 28 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Augusta County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID LANDES</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET - FIFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>LUCILLE PORTER, Rosemont</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant melanoma with metastases</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>57</u> , to <u>12/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>12/6/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				Fredericks Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec. 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brunswick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elva V. Keeter</u>				ADDRESS <u>Brunswick Md.</u>		24a. REC'D BY REGISTRAR (DATE <u>12-8-57</u>) 24b. REGISTRAR'S SIGNATURE <u>Eugene H. Busch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John V. Chase</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Dec 10 1957</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Baltimore</i>		7. COUNTY <i>Harford</i>		8. STATE <i>Md.</i>	
9. OCCUPATION <i>Engineer</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>John V. Chase</i>	
13. SIGNATURE OF DECEASED <i>John V. Chase</i>		14. SIGNATURE OF WITNESS <i>John V. Chase</i>		15. SIGNATURE OF DECEASED <i>John V. Chase</i>		16. SIGNATURE OF WITNESS <i>John V. Chase</i>	
17. SIGNATURE OF DECEASED <i>John V. Chase</i>		18. SIGNATURE OF WITNESS <i>John V. Chase</i>		19. SIGNATURE OF DECEASED <i>John V. Chase</i>		20. SIGNATURE OF WITNESS <i>John V. Chase</i>	
21. SIGNATURE OF DECEASED <i>John V. Chase</i>		22. SIGNATURE OF WITNESS <i>John V. Chase</i>		23. SIGNATURE OF DECEASED <i>John V. Chase</i>		24. SIGNATURE OF WITNESS <i>John V. Chase</i>	
25. SIGNATURE OF DECEASED <i>John V. Chase</i>		26. SIGNATURE OF WITNESS <i>John V. Chase</i>		27. SIGNATURE OF DECEASED <i>John V. Chase</i>		28. SIGNATURE OF WITNESS <i>John V. Chase</i>	
29. SIGNATURE OF DECEASED <i>John V. Chase</i>		30. SIGNATURE OF WITNESS <i>John V. Chase</i>		31. SIGNATURE OF DECEASED <i>John V. Chase</i>		32. SIGNATURE OF WITNESS <i>John V. Chase</i>	
33. SIGNATURE OF DECEASED <i>John V. Chase</i>		34. SIGNATURE OF WITNESS <i>John V. Chase</i>		35. SIGNATURE OF DECEASED <i>John V. Chase</i>		36. SIGNATURE OF WITNESS <i>John V. Chase</i>	
37. SIGNATURE OF DECEASED <i>John V. Chase</i>		38. SIGNATURE OF WITNESS <i>John V. Chase</i>		39. SIGNATURE OF DECEASED <i>John V. Chase</i>		40. SIGNATURE OF WITNESS <i>John V. Chase</i>	
41. SIGNATURE OF DECEASED <i>John V. Chase</i>		42. SIGNATURE OF WITNESS <i>John V. Chase</i>		43. SIGNATURE OF DECEASED <i>John V. Chase</i>		44. SIGNATURE OF WITNESS <i>John V. Chase</i>	
45. SIGNATURE OF DECEASED <i>John V. Chase</i>		46. SIGNATURE OF WITNESS <i>John V. Chase</i>		47. SIGNATURE OF DECEASED <i>John V. Chase</i>		48. SIGNATURE OF WITNESS <i>John V. Chase</i>	
49. SIGNATURE OF DECEASED <i>John V. Chase</i>		50. SIGNATURE OF WITNESS <i>John V. Chase</i>		51. SIGNATURE OF DECEASED <i>John V. Chase</i>		52. SIGNATURE OF WITNESS <i>John V. Chase</i>	
53. SIGNATURE OF DECEASED <i>John V. Chase</i>		54. SIGNATURE OF WITNESS <i>John V. Chase</i>		55. SIGNATURE OF DECEASED <i>John V. Chase</i>		56. SIGNATURE OF WITNESS <i>John V. Chase</i>	
57. SIGNATURE OF DECEASED <i>John V. Chase</i>		58. SIGNATURE OF WITNESS <i>John V. Chase</i>		59. SIGNATURE OF DECEASED <i>John V. Chase</i>		60. SIGNATURE OF WITNESS <i>John V. Chase</i>	
61. SIGNATURE OF DECEASED <i>John V. Chase</i>		62. SIGNATURE OF WITNESS <i>John V. Chase</i>		63. SIGNATURE OF DECEASED <i>John V. Chase</i>		64. SIGNATURE OF WITNESS <i>John V. Chase</i>	
65. SIGNATURE OF DECEASED <i>John V. Chase</i>		66. SIGNATURE OF WITNESS <i>John V. Chase</i>		67. SIGNATURE OF DECEASED <i>John V. Chase</i>		68. SIGNATURE OF WITNESS <i>John V. Chase</i>	
69. SIGNATURE OF DECEASED <i>John V. Chase</i>		70. SIGNATURE OF WITNESS <i>John V. Chase</i>		71. SIGNATURE OF DECEASED <i>John V. Chase</i>		72. SIGNATURE OF WITNESS <i>John V. Chase</i>	
73. SIGNATURE OF DECEASED <i>John V. Chase</i>		74. SIGNATURE OF WITNESS <i>John V. Chase</i>		75. SIGNATURE OF DECEASED <i>John V. Chase</i>		76. SIGNATURE OF WITNESS <i>John V. Chase</i>	
77. SIGNATURE OF DECEASED <i>John V. Chase</i>		78. SIGNATURE OF WITNESS <i>John V. Chase</i>		79. SIGNATURE OF DECEASED <i>John V. Chase</i>		80. SIGNATURE OF WITNESS <i>John V. Chase</i>	
81. SIGNATURE OF DECEASED <i>John V. Chase</i>		82. SIGNATURE OF WITNESS <i>John V. Chase</i>		83. SIGNATURE OF DECEASED <i>John V. Chase</i>		84. SIGNATURE OF WITNESS <i>John V. Chase</i>	
85. SIGNATURE OF DECEASED <i>John V. Chase</i>		86. SIGNATURE OF WITNESS <i>John V. Chase</i>		87. SIGNATURE OF DECEASED <i>John V. Chase</i>		88. SIGNATURE OF WITNESS <i>John V. Chase</i>	
89. SIGNATURE OF DECEASED <i>John V. Chase</i>		90. SIGNATURE OF WITNESS <i>John V. Chase</i>		91. SIGNATURE OF DECEASED <i>John V. Chase</i>		92. SIGNATURE OF WITNESS <i>John V. Chase</i>	
93. SIGNATURE OF DECEASED <i>John V. Chase</i>		94. SIGNATURE OF WITNESS <i>John V. Chase</i>		95. SIGNATURE OF DECEASED <i>John V. Chase</i>		96. SIGNATURE OF WITNESS <i>John V. Chase</i>	
97. SIGNATURE OF DECEASED <i>John V. Chase</i>		98. SIGNATURE OF WITNESS <i>John V. Chase</i>		99. SIGNATURE OF DECEASED <i>John V. Chase</i>		100. SIGNATURE OF WITNESS <i>John V. Chase</i>	

BUREAU V. S.

DEC 10 1957

RECEIVED

13114

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FRED. MEMORIAL HOSP.				d. STREET ADDRESS RT #3 Bloomfield			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First STEVEN Middle Douglas Last FISHER				4. DATE OF DEATH Month DEC. Day 19 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/3/56	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME GRAYSON FISHER				14. MOTHER'S MAIDEN NAME JESSIE SPANGLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Grayson L. Fisher (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (GENERALIZED) RETICULOENDOTHELIOSIS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/3/56 , 19 56 , to 12/19 , 19 57 , that I last saw the deceased alive on 12/19 , 19 57 , and that death occurred at 8 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 12-19-57 ACTUAL SIGNATURE F. J. Heldrich M.D. F. J. Heldrich PHYSICIAN'S NAME (Type) F. J. Heldrich, M. D. 220 N. Market St., Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR 21 Dec 1957	
				24b. REGISTRAR'S SIGNATURE Elizabeth Heck			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11-11-1964 (1964-11-11)

BUREAU V. S.

DEC 26 1957

RECEIVED

13115 CERTIFICATE OF DEATH

13121
 Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS Near Doubs			
3. NAME OF DECEASED (Type or print) First CAREY Middle WEBSTER Last FITZE				4. DATE OF DEATH Month December Day 26 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Jan 1956	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Elmer T. Fitze				14. MOTHER'S MAIDEN NAME Helen Stine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elmer T. Fitze		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema 560.0 DUE TO cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rt undrained inguinal hernia repair (c) 3 1/2 days							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10/29 , 19 57 , to 12/26 , 19 57 , that I last saw the deceased alive on 12/26 , 19 57 , and that death occurred at 8:30 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 W. 3rd St., Frederick, Md. DATE SIGNED 12-28-57							
ACTUAL SIGNATURE Frank S. Damazo				M.D. Frank S. Damazo, M. D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REBURY (Specify) BURIAL		22b. DATE THEREOF 12-30-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR Elizabeth G. Heck	
24b. REGISTRAR'S SIGNATURE							

13116

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK CITY		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle FLOOK Last 1		4. DATE OF DEATH Month DECEMBER Day 11 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 20 1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH.CO.MD.U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME SIMON SUMMERS		14. MOTHER'S MAIDEN NAME EMMALINE ZITTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT SAMUEL FLOOK MYERSVILLE MD ROUTE 1.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 6 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia INTERVAL BETWEEN ONSET AND DEATH 3 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-23 , 19 57 , to 12-11 , 19 57 , that I last saw the deceased alive on 12-11 , 19 57 , and that death occurred at 12 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4W 3 rd st DATE SIGNED 12-11-57			
ACTUAL SIGNATURE Thomas E Stone M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 14 1957	
22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Barb Lull Howe Boonsboro Md.		24a. REC'D BY REGISTRAR DATE 17 Dec 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G224 1-17-58 et

CERTIFICATE OF DEATH

13117

13123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home for the Aged-115 Record St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cora Middle Freeman Last Freeman				4. DATE OF DEATH Month Dec. Day 2 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. WIDOWED WIDOWED		8. DATE OF BIRTH 2-18-1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper & Dress Maker				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George E. Diller				14. MOTHER'S MAIDEN NAME Annie Thomas Diller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-26-5567			
17. INFORMANT Records-Home for the Aged-Frederick-Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Arterio-sclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? INTERVAL BETWEEN ONSET AND DEATH ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 18 Nov. , 19 57 to 2 Dec. , 19 57 , that I last saw the deceased alive on 18 Nov. , 19 57 , and that death occurred at 9 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED Charles H. Conley Jr.							
ACTUAL SIGNATURE Charles H. Conley Jr. M.D. Frederick-Maryland							
PHYSICIAN'S NAME (Type) Dr. Chas. H. Conley-Jr. Frederick-Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-4-1957			
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				22d. LOCATION (City, town, or county) (State) Frederick-Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick-Md.			
24a. REC'D BY REGISTRAR 4 Dec. 1957				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13140

CERTIFICATE OF DEATH

13124

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont RD 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountaindale x2 Thurmont, RD 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Luther Middle Thomas Last Geesey		4. DATE OF DEATH Month December Day 27 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1882
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Geesey		14. MOTHER'S MAIDEN NAME Sophia Alice Shook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-2147	
17. INFORMANT Stella Geesey Thurmont RD 1 Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 18 months 10 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 52 to 27 Dec , 19 57 , that I last saw the deceased alive on 26 Dec , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WALKERSVILLE Md. DATE SIGNED 28 Dec 1957			
ACTUAL SIGNATURE James E. Stoner Jr M.D.		PHYSICIAN'S NAME (Type) James E. Stoner Jr	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57	
22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		22d. LOCATION (City, town, or county) (State) Lewistown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE DEC 31 '57		24b. REGISTRAR'S SIGNATURE W. L. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF DECEASED [Faint text]		15. SIGNATURE OF DECEASED [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]		21. SIGNATURE OF DECEASED [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF DECEASED [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]		33. SIGNATURE OF DECEASED [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]		39. SIGNATURE OF DECEASED [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]		45. SIGNATURE OF DECEASED [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]		51. SIGNATURE OF DECEASED [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]		57. SIGNATURE OF DECEASED [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]		63. SIGNATURE OF DECEASED [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]		69. SIGNATURE OF DECEASED [Faint text]	
70. SIGNATURE OF DECEASED [Faint text]		71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]		75. SIGNATURE OF DECEASED [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]		81. SIGNATURE OF DECEASED [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]		87. SIGNATURE OF DECEASED [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]		93. SIGNATURE OF DECEASED [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]		99. SIGNATURE OF DECEASED [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF DECEASED [Faint text]		102. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. E.

DEC 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G224 1-6-58 et

13118

CERTIFICATE OF DEATH.

13125

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 BRUNSWICK</u>				d. STREET ADDRESS <u>112-1st Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fredericks Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>B</u> Last <u>Gordon</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/08</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS WIGGINGTON</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Metz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>JAMES R. GORDON</u> Address <u>112-1st Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the breast with</u> DUE TO <u>generalized metastases</u> (c) <u>3 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/26</u> , 19 <u>57</u> , to <u>12/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>57</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D. <u>H E Church St</u>				DATE SIGNED <u>12/26/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> <u>Frederick Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brunswick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elva V. Teete Brunswick Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>12-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Eugenia L. Burke</u>	

DEC 31 1957

BUREAU V. S.

RECEIVED

13131

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRUNSWICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 New Addition			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 EAST "C" ST.				d. STREET ADDRESS 1 -			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE - CECILIA - GOSNELL				4. DATE OF DEATH Month Day Year Dec. 6 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17 1887	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -				14. MOTHER'S MAIDEN NAME JENNY COOPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT EURLY Gosnell		Address BRUNSWICK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary Edema 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) acute Congestive Failure DUE TO (c) 5 yrs.						INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1947 to 12/6 1957 , that I last saw the deceased alive on 12/6 1957 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 12/6/57							
ACTUAL SIGNATURE W.B. Compunter M.D.							
PHYSICIAN'S NAME (Type) E. V. Teeter Brunswick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-57		22c. NAME OF CEMETERY OR CREMATORY Knoxville Cemetery		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. V. Teeter Brunswick, Md.				24a. REC'D BY REGISTRAR DATE 12-9-57		24b. REGISTRAR'S SIGNATURE Eugenia H. Burke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13127

13:41

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 1498 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle V. Last Green				4. DATE OF DEATH Month 12 Day 9 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/1902	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Green				14. MOTHER'S MAIDEN NAME Susan E. Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 238-09-8564		17. INFORMANT Address Records of Victor Cullen Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 9 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov. 2, 1953 , to Dec. 9, 1957 , that I last saw the deceased alive on Dec. 9, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Md. DATE SIGNED Dec. 9, 1957							
ACTUAL SIGNATURE T. F. Vestal				M.D. _____			
PHYSICIAN'S NAME (Type) T. F. Vestal							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-57		22c. NAME OF CEMETERY OR CREMATORY Spindale Cemetery		22d. LOCATION (City, town, or county) (State) Spindale, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE M. H. Cragg				24a. REC'D BY REGISTRAR DATE DEC 11 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Signature of Physician		Signature of Registrar	
William Green		Male		35		White		1900-01-01		1935-01-01		Home		Heart Disease		Coronary Artery Disease		Farmer		J. M. Green		J. M. Green	
Place of Birth		County		State		Married		Single		Married		Married		Married		Married		Married		Married		Married	
North Carolina		Wayne		North Carolina		Yes		No		Yes		Yes		Yes		Yes		Yes		Yes		Yes	
Spouse's Name		Spouse's Birth		Spouse's Death		Spouse's Cause		Spouse's Disease		Spouse's Occupation		Spouse's Signature		Spouse's Signature		Spouse's Signature		Spouse's Signature		Spouse's Signature		Spouse's Signature	
Sarah E. Green		1900-01-01		1935-01-01		Heart Disease		Coronary Artery Disease		Farmer		J. M. Green		J. M. Green		J. M. Green		J. M. Green		J. M. Green		J. M. Green	
Date of Marriage		Date of Divorce		Date of Remarriage		Date of Death of Spouse		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased	
1920-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01	
Date of Death of Spouse		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased	
1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01	
Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased		Date of Death of Deceased	
1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01		1935-01-01	

BUREAU V. S.

DEC 11 1937

RECEIVED

13'42 CERTIFICATE OF DEATH

Reg. Dist. No. 87

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL, JOHNSVILLE</u>		d. STREET ADDRESS <u>JOHNSVILLE</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>PETER</u> Middle <u>GREEN</u> Last		4. DATE OF DEATH <u>DEC</u> Month <u>18</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 23 - 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH OWN SHOP</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PERRY GREEN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN LONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOHN D GREEN</u> Address <u>JOHNSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-15-</u> , 19 <u>57</u> , to <u>12-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-18-</u> , 19 <u>57</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Ligg</u> M.D.		ADDRESS (Street, city or town, State) <u>Union Bridge, Maryland</u> DATE SIGNED <u>12-19-57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Thomas H. Ligg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC 22-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Hartley & Sons Union Bridge Md</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>12/20/57</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Luther Powell, ES.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

DEC 23 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 54 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Rosemont Avenue		d. STREET ADDRESS 700 Rosemont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last GROVE		4. DATE OF DEATH Month December Day 9 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Developer		12. KIND OF BUSINESS OR INDUSTRY Real Estate	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME David Grove		16. MOTHER'S MAIDEN NAME Marrietta Bopst	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT Mrs. Amy B. Grove-Same as item #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 7, 1957 , to Dec 9, 1957 , that I last saw the deceased alive on Dec 9, 1957 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearre		ADDRESS (Street, city or town, state) East Church Street, Frederick, Maryland	
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre		DATE SIGNED 12/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/10/1957	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR 10 Dec 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hecks	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1900		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Carpenter		High School		Married		Catholic		White		White		Brown		Blue	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		SECOND	
Heart Failure		Natural		Home		DEC 10 1945		10:30		PM		00		00	
PREVIOUS ILLNESS		TREATMENT		NAMES OF PHYSICIANS		HOSPITAL		NAMES OF SURGEONS		OPERATION		DATE OF OPERATION		PLACE OF OPERATION	
None		None		Dr. J. H. Smith		None		Dr. J. H. Smith		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF OFFICIAL	

BUREAU V. H.

DEC 12 1945

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Samuel Middle J. Last Huffer				4. DATE OF DEATH Month 11 Day 14 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1957	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob Huffer			14. MOTHER'S MAIDEN NAME Feba Huffer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Austin Huffer, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Advanced Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June , 1956, to Dec 14 , 1957, that I last saw the deceased alive on Nov 30 , 1957, and that death occurred at 1 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE SELMER HARP			ADDRESS (Street, city or town, state) Middletown		DATE SIGNED 12-15-57		
PHYSICIAN'S NAME (Type) SELMER HARP							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/16/1957	22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.			24a. REC'D BY REGISTRAR 18 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 20 1957

RECEIVED

13120

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle E. Last Johnson		4. DATE OF DEATH Month 12 Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1861
9. AGE (In years last birthday) yrs. 96		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel W. George		14. MOTHER'S MAIDEN NAME Esta Grubb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Freada Johnson, Lovettsville, Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with infarction of 332X DUE TO brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7 , 19 57 , to 12/10 , 19 57 , that I last saw the deceased alive on 12/9 , 19 57 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 12/10/57 ACTUAL SIGNATURE Henry V. Chase M.D. Frederick Md PHYSICIAN'S NAME (Type) Henry V. Chase			
22a. BURIAL CREMATION, Removal (Specify) Burial		22b. DATE THEREOF Dec. 12, 1957	
22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 10 Dec 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased James E. Jones		2. Sex Male		3. Race White	
4. Date of birth 1900		5. Date of death 1957		6. Place of birth Baltimore, Maryland	
7. Usual residence Baltimore, Maryland		8. Cause of death Heart disease		9. Manner of death Natural	
10. Signature of physician [Signature]		11. Signature of registrar [Signature]		12. Signature of informant [Signature]	
13. Date of registration 1957		14. County Baltimore		15. State Maryland	
16. Registrar's name [Name]		17. Registrar's title Registrar		18. Registrar's address [Address]	
19. Registrar's telephone [Number]		20. Registrar's office [Office]		21. Registrar's district [District]	
22. Registrar's signature [Signature]		23. Registrar's seal [Seal]		24. Registrar's stamp [Stamp]	
25. Registrar's date 1957		26. Registrar's time [Time]		27. Registrar's place [Place]	
28. Registrar's office [Office]		29. Registrar's district [District]		30. Registrar's state Maryland	
31. Registrar's county Baltimore		32. Registrar's city Baltimore		33. Registrar's street [Street]	
34. Registrar's apartment [Apartment]		35. Registrar's zip code 21201		36. Registrar's phone [Phone]	
37. Registrar's fax [Fax]		38. Registrar's email [Email]		39. Registrar's website [Website]	
40. Registrar's social media [Social Media]		41. Registrar's other contact [Other Contact]		42. Registrar's notes [Notes]	

BUREAU V. E.

DEC 12 1957

RECEIVED

13144

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Woodsboro</u>		c. LENGTH OF STAY IN 1b <u>X2 Woodsboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mickey Matholan Keeney</u>		4. DATE OF DEATH <u>December 25 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1930 27</u> yrs.
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver Truck</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOTTLING PLANT</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Henry M. Keeney</u>		14. MOTHER'S MAIDEN NAME <u>Helen Derr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1944-1947</u>		16. SOCIAL SECURITY NO. <u>218-24-2028</u>	
17. INFORMANT <u>Robert Keeney</u>		Address <u>Frederick RD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning accidental</u> 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:30 p.m. 12.25.57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		22d. LOCATION (City, town, or county) <u>WOODSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Powell & Hartzler Woodsboro Md</u>		24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ely G. Kelly</u>	

RECEIVED

DEC 31 1957

BUREAU V. 2

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

13121

CERTIFICATE OF DEATH

Reg. Dist. No.

121

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Rural-- Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Clara</u> First <u>V.</u> Middle <u>Maisel</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/75</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ludwig Maisel</u>		14. MOTHER'S MAIDEN NAME <u>Annie V. Foreman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs. Dova Ecker, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/23</u> , 19 <u>57</u> , to <u>12/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>57</u> , and that death occurred at <u>12:41</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>12/24/57</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-27-1957</u>	22c. NAME OF CEMETERY <u>Locust Grove Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Ely H. Hays</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13134

13122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 14 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 419 Klinehart Alley	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Norma Bell Marshall		4. DATE OF DEATH December 18	Day 08 Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1894
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hand Sewer		10b. KIND OF BUSINESS OR INDUSTRY Tailoring Co.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Howard Ramsberg	
14. MOTHER'S MAIDEN NAME Mary Cline Rice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-14-9048		17. INFORMANT Raymond Cligan, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Y.C. Barten		ADDRESS Walkersville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heik	
DATE 23 Dec 1957			

STATE OF MARYLAND
HEALTH DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 26 1957
BUREAU V. 2

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten text.

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 45 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle JOSEPH Last McDERMOTT		4. DATE OF DEATH Month December Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 22, 1881
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Iron & Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3478	
17. INFORMANT Mrs. L. William McCall		Address 407 Biggs Ave. Frederick, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153X DUE TO Carcinoma of Sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Decompensation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension + Hemiplegia			INTERVAL BETWEEN ONSET AND DEATH 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 1948, to Dec 24 , 1957, that I last saw the deceased alive on Dec 26 , 1957, and that death occurred at 7:15 AM , from the causes and on the date stated above. DATE SIGNED 12/27/57 ADDRESS (Street, city or town, state) East Second Street			
ACTUAL SIGNATURE H. L. Fahrney		M.D. Frederick, Maryland	
PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney		Frederick, Maryland	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Dec. 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR 30 Dec 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Hark

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1912		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES	
RACE		COLORED OR WHITE		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
White		White		Married		High School		Teacher		Heart Disease		Natural		Home	
RELIGION		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		PLACE OF INTERMENT	
Roman Catholic		1957		10:30 AM		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES		CATHOLIC CHURCH	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT		COUNTRY OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
1957		10:30 AM		CATHOLIC CHURCH		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES		CATHOLIC CHURCH	

RECEIVED
DEC 31 1957
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13136
Item 18 Film 223 12-17-57 ams										131
13145 CERTIFICATE OF DEATH										Reg. Dist. No. 131
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Braddock Heights					c. LENGTH OF STAY IN 1b 9 years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Braddock Heights
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home					d. STREET ADDRESS 1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ethel Middle M. Last Meehan					4. DATE OF DEATH Month Dec. Day 4th Year 19 57					
5. SEX Female	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26-1876		9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Gregg					14. MOTHER'S MAIDEN NAME Mary Catherine (Don't Know) Gregg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Frances Latterell-Braddock Hgts.-Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia RML & RLL 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture right hip DUE TO (c) Fall (Possibly a pathological fracture & then the fall)										INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1952 , to 12/4 , 1957 , that I last saw the deceased alive on 12/4 , 1957 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED										
ACTUAL SIGNATURE James B. Thomas M.D.					DATE SIGNED					
PHYSICIAN'S NAME (Type) Dr. James B. Thomas					ADDRESS Frederick-Maryland					
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-9-1957		22c. NAME OF CEMETERY OR CREMATORY J. Wm. Lee's Crematory		22d. LOCATION (City, town, or county) (State) Washington- D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son					ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 9 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13146

CERTIFICATE OF DEATH

13137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg.		c. LENGTH OF STAY IN 1b 35 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x/ Rural Emmitsburg,		d. STREET ADDRESS R.D.#2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maude Middle Manzella Last Ohler		4. DATE OF DEATH Month December Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1885
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Miller		14. MOTHER'S MAIDEN NAME Emma Jane Harbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Clyde Ohler		Address Emmitsburg, R.D.#2 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIO-RENAL DISEASE DUE TO (c) 12 YEARS		INTERVAL BETWEEN ONSET AND DEATH 5 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DECEMBER, 1957 , to DECEMBER, 1957 , that I last saw the deceased alive on 2 DECEMBER, 1957 , and that death occurred at 12:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James H. Hammett MD 12/2/57 ACTUAL SIGNATURE M.D. James H. Hammett MD PHYSICIAN'S NAME (Type) JAMES H. HAMMETT MD FAIRFIELD, PENNA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison		ADDRESS Emmitsburg, Md.	
24a. REC'D BY REGISTRAR DEC 5 '57		24b. REGISTRAR'S SIGNATURE Paul Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Alfano

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BUREAU V. S.

DEC 5 1967

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Mem.</u>		d. STREET ADDRESS <u>118 East St</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>OREM</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 30, 1957</u>
9. AGE (In years last birthday) yrs. <u>16</u>		IF UNDER 1 YEAR Months <u>16</u> Days <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clark Orem</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Sheppard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stenocarditis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>20 Dec., 1957</u> to <u>31 Dec., 1957</u> , that I last saw the deceased alive on <u>31 Dec., 1957</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Guest</u> M.D.		DATE SIGNED <u>7 E. Church St</u>	
PHYSICIAN'S NAME (Type) <u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-4-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u> ADDRESS <u>Frederick - Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 8 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Clyde H. H.</u>

2069294XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 2 should be filled with the registration number and date of death. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration number and date of death. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration number and date of death. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration number and date of death.

CERTIFICATE OF DEATH

REG. NO. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1893		BALTIMORE		MD		USA			
RACE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
WHITE		LABORER		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		HOME	
DATE OF DEATH		TIME OF DEATH		DAY OF WEEK		MONTH		YEAR		HOURS		MINUTES		SECONDS	
JAN 8 1938		10:30 AM		TUESDAY		JAN		1938		10		30		00	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS	
I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.		I, the undersigned, do hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health.	

Hospital Records

BUREAU V. E.

JAN 8 1938

RECEIVED

5 E. HARRIS - 1-4-38

13:47 CERTIFICATE OF DEATH

13139

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville				c. LENGTH OF STAY IN 1b 40yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ANDERS Last PEARRE				4. DATE OF DEATH Month DEC. Day 17 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-12-1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Calvin Anders				14. MOTHER'S MAIDEN NAME Anna Mary Repp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Elmer Pittinger, Union Bridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH suddenly							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3/11/56 , 19____, to 12/17/57 , 19____, that I last saw the deceased alive on 11/25/57 , 19____, and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) New Windsor, Md. DATE SIGNED 12/17/57							
ACTUAL SIGNATURE M. E. Robertson M.D. M.D.				DATE SIGNED 12/17/57			
PHYSICIAN'S NAME (Type) M. E. Robertson M.D.				ADDRESS New Windsor, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-20-1957		22c. NAME OF CEMETERY OR CREMATORY Linganore		22d. LOCATION (City, town, or county) (State) Unionville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DEC 22 1957	
24b. REGISTRAR'S SIGNATURE E. J. Heck							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13125 CERTIFICATE OF DEATH

13140

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN TB 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last Maurice F. Remsburg				4. DATE OF DEATH Month Day Year 12 21 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1883	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sexton		10b. KIND OF BUSINESS OR INDUSTRY church		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Remsburg				14. MOTHER'S MAIDEN NAME Mahala Kefauver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Elva Pepper, Princeton Jct., N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis with myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12/18 , 19 57 , to 12/21 , 19 57 , that I last saw the deceased alive on 12/20 , 19 57 , and that death occurred at 7 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Chase		M.D. 4 E. Church St		DATE SIGNED 12/31/57			
PHYSICIAN'S NAME (Type) Henry V. Chase		Frederick Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/24/1957		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co.,				ADDRESS Middletown, Md.		24a. REC'D BY REGISTRAR DATE 26 Dec 1957	
						24b. REGISTRAR'S SIGNATURE Elizabeth L. Heak	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <i>Henry C. Remond</i></p>	
<p>DATE OF BIRTH: <i>1912</i></p>	<p>PLACE OF BIRTH: <i>France</i></p>
<p>DATE OF DEATH: <i>Dec 27 1957</i></p>	<p>PLACE OF DEATH: <i>Home</i></p>
<p>CAUSE OF DEATH: <i>Heart failure</i></p>	
<p>DIAGNOSIS: <i>Myocardial infarction</i></p>	
<p>DATE OF EXAMINATION: <i>Dec 27 1957</i></p>	
<p>SIGNATURE OF PHYSICIAN: <i>Henry C. Remond</i></p>	
<p>DATE OF SIGNATURE: <i>Dec 27 1957</i></p>	
<p>NAME OF REGISTRAR: <i>Henry C. Remond</i></p>	
<p>DATE OF REGISTRATION: <i>Dec 27 1957</i></p>	

BUREAU V.

DEC 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13141

13126

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 East 4th St.		d. STREET ADDRESS 108 West 4th St.	
3. NAME OF DECEASED (Type or print) First James Middle Clayton Last Rowe		4. DATE OF DEATH Month December Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARITAL STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 4 Hours 27 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Rowe		14. MOTHER'S MAIDEN NAME Barbara Shroedel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-32-5526	
17. INFORMANT Mrs. Clarence R. Slack-31 E. 4th St. Frederick-		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 42a1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO 10 years (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1950 , to Dec. 13, 1957 , that I last saw the deceased alive on Dec. 12, 1957 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. 1214/57 DATE SIGNED _____ ACTUAL SIGNATURE B. O. Thomas M.D. Professional Bldg. PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr. 228 North Market Street - Frederick-Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-1957	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR 16 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Herb	

RECEIVED

DEC 19 1957

BUREAU V. E.

13127 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle ALBERT Last SCHUOLER				4. DATE OF DEATH Month December Day 11 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 June 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Schuoler		14. MOTHER'S MAIDEN NAME Anna Marie Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-34-5638		17. INFORMANT Mrs. Lulu Schuoler (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1938, to Dec 11 , 1957, that I last saw the deceased alive on Dec 11 , 1957, and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 E. 2nd St., Frederick, Md. DATE SIGNED 12-12-57 ACTUAL SIGNATURE H. Lawrence Fahrney M.D. PHYSICIAN'S NAME (Type) H. Lawrence Fahrney, M. D.							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 13 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED NEW BRITAIN		AGE 10		SEX M		RACE W		DATE OF BIRTH 1947		PLACE OF BIRTH NEW BRITAIN, CT	
OCCUPATION Student		EDUCATION High School		MARRIAGE Never		RELIGION Catholic		DATE OF DEATH 1957		PLACE OF DEATH New Britain, CT	
CAUSE OF DEATH Sudden		MANNER OF DEATH Natural		DURATION OF ILLNESS None		PREVIOUS ILLNESS None		DATE OF ONSET None		DATE OF TERMINATION None	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF DECEASED [Signature]	
DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957	

BUREAU V. S.

DEC 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13143

13148

CERTIFICATE OF DEATH

Reg. Dist. No.

147

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 2		d. STREET ADDRESS R.F.D. 2	
3. NAME OF DECEASED (Type or print) First FRANK Middle BAILEY Last SHAFFAR		4. DATE OF DEATH Month December Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1881
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpet layer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry I. Shaffar		14. MOTHER'S MAIDEN NAME Frances Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-28-8677	
17. INFORMANT Edna Hoge Shaffar-R.F.D. 2, Mt. Airy		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension and arteriosclerosis DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis, due to bronchial asthma 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 , 19 to 1957 , 19, that I last saw the deceased alive on Nov 23, 1957 , and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W.B. Culwell M.D. PHYSICIAN'S NAME (Type) W.B. Culwell Mt Airy, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600		ADDRESS Liberty Hgts. Ave.	
24a. REC'D BY REGISTRAR DEC 17 1957		24b. REGISTRAR'S SIGNATURE Clarice Pankley	

DEC 17 1957

BUREAU

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13149

CERTIFICATE OF DEATH

13144

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vindobona Convalescent Home</u>				STREET ADDRESS <u>Route 5</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Minnie SINES</u>				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>11</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/10/78</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Hartsock</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Joseph W Sines, Frederick, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterio sclerotic ulcers of feet</u>						9 Months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/12</u> , 19 <u>57</u> , to <u>12/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>57</u> , and that death occurred at <u>3:30 p.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J.R. Scholten</u>				ADDRESS (Street, city, town, state) <u>228 N. Main St. Frederick</u>		DATE SIGNED <u>12/11/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/14/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) <u>Middletown, Md.</u>	
24. REC'D BY REGISTRAR <u>16 Dec. 1957</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

Form No. 10-54

Place of death

County

City

Street

Room

Age

Sex

Color

Married

Occupation

Education

Religion

Birth date

Birth place

Death date

Time of death

Cause of death

Immediate cause

Underlying cause

Contributing cause

Mode of death

Signature of physician

Signature of coroner

Signature of registrar

Signature of witness

Signature of family

Signature of neighbor

Signature of clergyman

Signature of funeral director

Signature of undertaker

Signature of cemetery

Signature of burial

Signature of interment

Signature of final disposition

BUREAU V. B.

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13128

CERTIFICATE OF DEATH

13145

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 4 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Mary J. Slagle				4. DATE OF DEATH Month Day Year December 7 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1903		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William W. Pickett				14. MOTHER'S MAIDEN NAME Annie C. Hargett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Charles Slagle, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma left ovary DUE TO (c) 16 mos							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11 Nov , 19 57 , to 7 Dec , 19 57 , that I last saw the deceased alive on 7 Dec , 19 57 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Robert H. Pilgram M.D. Frederick, Md. 7 Dec 57 PHYSICIAN'S NAME (Type) Robert H. Pilgram Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-10-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DEC 10 1957	
				24b. REGISTRAR'S SIGNATURE Ely Rich			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARYLAND		25		F		W		1932		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
1957		10:00 AM		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		10:00 AM		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
HEART DISEASE		NATURAL		Nurse		High School		Roman Catholic		Married		1950		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
1957		10:00 AM		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1957		10:00 AM		BALTIMORE	

BUREAU V. S.

DEC. 10 1957

RECEIVED

13150

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				c. LENGTH OF STAY IN 1b 51 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Meade Garfield Smith				4. DATE OF DEATH Month Day Year December 17 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1880	9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Gen. Labor		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
13. FATHER'S NAME Sameul Smith				14. MOTHER'S MAIDEN NAME Barbara Toms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Annie Smith, Myersville, Md. Rt. #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14, 1957 , to Dec 17, 1957 , that I last saw the deceased alive on Dec 14, 1957 , and that death occurred at 4:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middletown DATE SIGNED 12-17-57							
ACTUAL SIGNATURE J Elmer Harp M.D.				PHYSICIAN'S NAME (Type) J ELMER HARP			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-1957		22c. NAME OF CEMETERY OR CREMATORY Pleasant Walk U.B. Nr. Myersville, Fred. Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle ADDRESS Paul F. Bittle, Myersville, Md.				24a. REC'D BY REGISTRAR DATE 12-18-57		24b. REGISTRAR'S SIGNATURE Floyd M. Bittle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13151 CERTIFICATE OF DEATH

13147

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Blue Ridge Summit	c. LENGTH OF STAY IN 1b 30 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Blue Ridge Summit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Laertes Middle Pittman Last Springs		4. DATE OF DEATH Month Dec. Day 15, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1891
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Diplomatic Service	10b. KIND OF BUSINESS OR INDUSTRY Winston Salem N. C.
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Springs		14. MOTHER'S MAIDEN NAME Bobo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 1	
17. INFORMANT Mrs. Marjory Fraser Springs, Blue Ridge Summit Pa		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 30 Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 Dec. , 19 57 , to 15 Dec. , 19 57 , that I last saw the deceased alive on 15 Dec. , 19 57 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert A. Leifer M.D. Blue Ridge Summit, Pa. 15 Dec 57 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Z. Grove Waynesboro Pa		24a. REC'D BY REGISTRAR DATE DEC 18 '57	24b. REGISTRAR'S SIGNATURE West

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

13'52
CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). KNOXVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO KNOXVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #1		d. STREET ADDRESS 1 R.F.D. #1	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN - WILLIAM - TURNER		4. DATE OF DEATH Month Day Year Dec. 26 1957	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD LINEMAN		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY TURNER		14. MOTHER'S MAIDEN NAME HATTIE CASTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. J. W. TURNER		Address KNOXVILLE Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sub-acute Bronchitis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-1-57 , to 12-26-57 , that I last saw the deceased alive on 12-26-57 , and that death occurred at 5:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		DATE SIGNED 12-26-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-28-57	22c. NAME OF CEMETERY OR CREMATORY BROWNSVILLE	22d. LOCATION (City, town, or county) (State) Brownsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. V. Felt		ADDRESS Brownsville Md.	
24a. REC'D BY REGISTRAR DATE 12-29-57		24b. REGISTRAR'S SIGNATURE Eugenia L. Burke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John P. Jones</i>		2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
3. AGE <i>65</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Dec 31 1957</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNNATURAL	
11. SIGNATURE OF PHYSICIAN <i>John P. Jones</i>		12. SIGNATURE OF REGISTRAR <i>John P. Jones</i>	
13. SIGNATURE OF WITNESSES <i>John P. Jones</i>		14. SIGNATURE OF DECEASED <i>John P. Jones</i>	
15. SIGNATURE OF DECEASED <i>John P. Jones</i>		16. SIGNATURE OF DECEASED <i>John P. Jones</i>	
17. SIGNATURE OF DECEASED <i>John P. Jones</i>		18. SIGNATURE OF DECEASED <i>John P. Jones</i>	
19. SIGNATURE OF DECEASED <i>John P. Jones</i>		20. SIGNATURE OF DECEASED <i>John P. Jones</i>	
21. SIGNATURE OF DECEASED <i>John P. Jones</i>		22. SIGNATURE OF DECEASED <i>John P. Jones</i>	
23. SIGNATURE OF DECEASED <i>John P. Jones</i>		24. SIGNATURE OF DECEASED <i>John P. Jones</i>	
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31. SIGNATURE OF DECEASED <i>John P. Jones</i>		32. SIGNATURE OF DECEASED <i>John P. Jones</i>	
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49. SIGNATURE OF DECEASED <i>John P. Jones</i>		50. SIGNATURE OF DECEASED <i>John P. Jones</i>	
51. SIGNATURE OF DECEASED <i>John P. Jones</i>		52. SIGNATURE OF DECEASED <i>John P. Jones</i>	
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55. SIGNATURE OF DECEASED <i>John P. Jones</i>		56. SIGNATURE OF DECEASED <i>John P. Jones</i>	
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65. SIGNATURE OF DECEASED <i>John P. Jones</i>		66. SIGNATURE OF DECEASED <i>John P. Jones</i>	
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69. SIGNATURE OF DECEASED <i>John P. Jones</i>		70. SIGNATURE OF DECEASED <i>John P. Jones</i>	
71. SIGNATURE OF DECEASED <i>John P. Jones</i>		72. SIGNATURE OF DECEASED <i>John P. Jones</i>	
73. SIGNATURE OF DECEASED <i>John P. Jones</i>		74. SIGNATURE OF DECEASED <i>John P. Jones</i>	
75. SIGNATURE OF DECEASED <i>John P. Jones</i>		76. SIGNATURE OF DECEASED <i>John P. Jones</i>	
77. SIGNATURE OF DECEASED <i>John P. Jones</i>		78. SIGNATURE OF DECEASED <i>John P. Jones</i>	
79. SIGNATURE OF DECEASED <i>John P. Jones</i>		80. SIGNATURE OF DECEASED <i>John P. Jones</i>	
81. SIGNATURE OF DECEASED <i>John P. Jones</i>		82. SIGNATURE OF DECEASED <i>John P. Jones</i>	
83. SIGNATURE OF DECEASED <i>John P. Jones</i>		84. SIGNATURE OF DECEASED <i>John P. Jones</i>	
85. SIGNATURE OF DECEASED <i>John P. Jones</i>		86. SIGNATURE OF DECEASED <i>John P. Jones</i>	
87. SIGNATURE OF DECEASED <i>John P. Jones</i>		88. SIGNATURE OF DECEASED <i>John P. Jones</i>	
89. SIGNATURE OF DECEASED <i>John P. Jones</i>		90. SIGNATURE OF DECEASED <i>John P. Jones</i>	
91. SIGNATURE OF DECEASED <i>John P. Jones</i>		92. SIGNATURE OF DECEASED <i>John P. Jones</i>	
93. SIGNATURE OF DECEASED <i>John P. Jones</i>		94. SIGNATURE OF DECEASED <i>John P. Jones</i>	
95. SIGNATURE OF DECEASED <i>John P. Jones</i>		96. SIGNATURE OF DECEASED <i>John P. Jones</i>	
97. SIGNATURE OF DECEASED <i>John P. Jones</i>		98. SIGNATURE OF DECEASED <i>John P. Jones</i>	
99. SIGNATURE OF DECEASED <i>John P. Jones</i>		100. SIGNATURE OF DECEASED <i>John P. Jones</i>	

BUREAU V. S.

DEC 31 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13149

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wolfsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wolfsville</u>	
c. LENGTH OF STAY IN 1b <u>50 years</u>		d. STREET ADDRESS <u>7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>Warrenfeltz</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob B. Miller</u>		14. MOTHER'S MARDEN NAME <u>Hannah (?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Charles E. Warrenfeltz</u>		Address <u>Wyersville Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		DATE SIGNED <u>December 20 1957</u>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/23/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Welty's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 26 Dec. 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Elizabeth L. Heck</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 West Main Street				e. STREET ADDRESS 17 West Main Street			
3. NAME OF DECEASED (Type or print) First John Middle Bernard Last Welty				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1867	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Welty				14. MOTHER'S MAIDEN NAME Ellen Hobbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Edward W. Selig Address 17 West Main St. Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 422.2 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture inferior & superior ramus right pubis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9 , 19 55 , to 12/25 , 19 57 , that I last saw the deceased alive on 12/24 , 19 57 , and that death occurred at 10:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Emmitsburg, Md. DATE SIGNED Dec. 26, 1957 ACTUAL SIGNATURE Charles R. Williams M.D. Emmitsburg, Md. PHYSICIAN'S NAME (Type) Charles R. Williams Emmitsburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Catholic		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison ADDRESS Emmitsburg, Md.				24a. REC'D BY REGISTRAR DEC 28 57		24b. REGISTRAR'S SIGNATURE Arthur	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13155

CERTIFICATE OF DEATH

13151

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Fredrick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>x2 Walkersville</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MINNIE FRACK WINEBRENNER</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John W. Frack</u>				14. MOTHER'S MAIDEN NAME <u>Laura Jane Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Mr. James Trines, Walkersville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 19 <u>50</u> , to <u>26 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 Dec</u> , 19 <u>57</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>WALKERSVILLE, Md</u> DATE SIGNED <u>26 Dec 1957</u>							
ACTUAL SIGNATURE <u>James E. Stover, Jr.</u> M.D.				DATE SIGNED <u>26 Dec 1957</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STOVER, JR.</u>				ADDRESS <u>WALKERSVILLE, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 29, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W. Leasore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Barton</u>				24a. REC'D BY REGISTRAR <u>DATE 28 Dec 1957</u>			
ADDRESS <u>Walkersville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heick</u>			

CERTIFICATE OF DEATH

3155

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

DEC 31 1957

RECEIVED

Reg. Dist. No

MEDICAL CERTIFICATION

VS AIS (4)
ISM 9/SS

CERTIFICATE OF DEATH

Form DH-100 (Rev. 1-55)

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 15 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>None</i>		17. SIGNATURE OF WITNESSES <i>None</i>		18. SIGNATURE OF PHYSICIAN <i>None</i>	
19. SIGNATURE OF REGISTRAR <i>None</i>		20. SIGNATURE OF CLERK <i>None</i>		21. SIGNATURE OF JURY <i>None</i>	
22. SIGNATURE OF JURY <i>None</i>		23. SIGNATURE OF JURY <i>None</i>		24. SIGNATURE OF JURY <i>None</i>	
25. SIGNATURE OF JURY <i>None</i>		26. SIGNATURE OF JURY <i>None</i>		27. SIGNATURE OF JURY <i>None</i>	
28. SIGNATURE OF JURY <i>None</i>		29. SIGNATURE OF JURY <i>None</i>		30. SIGNATURE OF JURY <i>None</i>	
31. SIGNATURE OF JURY <i>None</i>		32. SIGNATURE OF JURY <i>None</i>		33. SIGNATURE OF JURY <i>None</i>	
34. SIGNATURE OF JURY <i>None</i>		35. SIGNATURE OF JURY <i>None</i>		36. SIGNATURE OF JURY <i>None</i>	
37. SIGNATURE OF JURY <i>None</i>		38. SIGNATURE OF JURY <i>None</i>		39. SIGNATURE OF JURY <i>None</i>	
40. SIGNATURE OF JURY <i>None</i>		41. SIGNATURE OF JURY <i>None</i>		42. SIGNATURE OF JURY <i>None</i>	
43. SIGNATURE OF JURY <i>None</i>		44. SIGNATURE OF JURY <i>None</i>		45. SIGNATURE OF JURY <i>None</i>	
46. SIGNATURE OF JURY <i>None</i>		47. SIGNATURE OF JURY <i>None</i>		48. SIGNATURE OF JURY <i>None</i>	
49. SIGNATURE OF JURY <i>None</i>		50. SIGNATURE OF JURY <i>None</i>		51. SIGNATURE OF JURY <i>None</i>	
52. SIGNATURE OF JURY <i>None</i>		53. SIGNATURE OF JURY <i>None</i>		54. SIGNATURE OF JURY <i>None</i>	
55. SIGNATURE OF JURY <i>None</i>		56. SIGNATURE OF JURY <i>None</i>		57. SIGNATURE OF JURY <i>None</i>	
58. SIGNATURE OF JURY <i>None</i>		59. SIGNATURE OF JURY <i>None</i>		60. SIGNATURE OF JURY <i>None</i>	
61. SIGNATURE OF JURY <i>None</i>		62. SIGNATURE OF JURY <i>None</i>		63. SIGNATURE OF JURY <i>None</i>	
64. SIGNATURE OF JURY <i>None</i>		65. SIGNATURE OF JURY <i>None</i>		66. SIGNATURE OF JURY <i>None</i>	
67. SIGNATURE OF JURY <i>None</i>		68. SIGNATURE OF JURY <i>None</i>		69. SIGNATURE OF JURY <i>None</i>	
70. SIGNATURE OF JURY <i>None</i>		71. SIGNATURE OF JURY <i>None</i>		72. SIGNATURE OF JURY <i>None</i>	
73. SIGNATURE OF JURY <i>None</i>		74. SIGNATURE OF JURY <i>None</i>		75. SIGNATURE OF JURY <i>None</i>	
76. SIGNATURE OF JURY <i>None</i>		77. SIGNATURE OF JURY <i>None</i>		78. SIGNATURE OF JURY <i>None</i>	
79. SIGNATURE OF JURY <i>None</i>		80. SIGNATURE OF JURY <i>None</i>		81. SIGNATURE OF JURY <i>None</i>	
82. SIGNATURE OF JURY <i>None</i>		83. SIGNATURE OF JURY <i>None</i>		84. SIGNATURE OF JURY <i>None</i>	
85. SIGNATURE OF JURY <i>None</i>		86. SIGNATURE OF JURY <i>None</i>		87. SIGNATURE OF JURY <i>None</i>	
88. SIGNATURE OF JURY <i>None</i>		89. SIGNATURE OF JURY <i>None</i>		90. SIGNATURE OF JURY <i>None</i>	
91. SIGNATURE OF JURY <i>None</i>		92. SIGNATURE OF JURY <i>None</i>		93. SIGNATURE OF JURY <i>None</i>	
94. SIGNATURE OF JURY <i>None</i>		95. SIGNATURE OF JURY <i>None</i>		96. SIGNATURE OF JURY <i>None</i>	
97. SIGNATURE OF JURY <i>None</i>		98. SIGNATURE OF JURY <i>None</i>		99. SIGNATURE OF JURY <i>None</i>	
100. SIGNATURE OF JURY <i>None</i>		101. SIGNATURE OF JURY <i>None</i>		102. SIGNATURE OF JURY <i>None</i>	

BUREAU V. E.

DEC 20 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13'30

CERTIFICATE OF DEATH

Reg. Dist. No. 131

13153

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS Della		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle RICHARD Last YOUNG				4. DATE OF DEATH Month December 27, Day 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Aug. 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Hillery Young				14. MOTHER'S MAIDEN NAME Fannie F. Riggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lewis A. Young, RFD, Adamstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Appendiceal abscess with rupture DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, right upper lobe active.							INTERVAL BETWEEN ONSET AND DEATH 4 days 3 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 8 , 1957, to Dec 27 , 1957, that I last saw the deceased alive on Dec 27 , 1957, and that death occurred at 2:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St., Frederick, Md. DATE SIGNED 12-28-57							
ACTUAL SIGNATURE Henry V. Chase M.D.							
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORY Della Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 30 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

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